b. CITY (if outside corporate limits, write RURAL and give township)  OR  OR  TOWN  Maryland Heights  d. FULL NAME OF (if not is hospital or institution, give street address or location) HOSPITAL OR INSTITUTION  DOTSett & Mikel Avenues  3. NAME OF DECEASED  (Type or Print)  Female  White  Widowed  Town  Maryland Heights  d. STREET (If rursl, give location)  ADDRESS  DOTSett & Mikel Avenues  DOTSett & Mikel Avenues  C. (Last)  DOTSett & Mikel Avenues  OF TOWN  Maryland Heights  d. STREET (If rursl, give location)  ADDRESS  DOTSett & Mikel Avenues  OF TOWN  Maryland Heights  d. STREET (If rursl, give location)  ADDRESS  DOTSett & Mikel Avenues  OF TOWN  Maryland Heights  d. STREET (If rursl, give location)  ADDRESS  DOTSett & Mikel Avenues  OF TOWN  Maryland Heights  d. STREET (If rursl, give location)  ADDRESS  DOTSett & Mikel Avenues  OF TOWN  Maryland Heights  d. STREET (If rursl, give location)  ADDRESS  DOTSett & Mikel Avenues  OF TOWN  MARYland Heights  DOTSET  NO TOWN  MARYland Heights  DOTSET  NO TOWN  MARYland Heights  DOTSET  OF TOWN  MARYLAND  ADDRESS  DOTSET  ADDRESS  DOTSET  Unstanting  OF TOWN  MARYLAND  ADDRESS  DOTSET  OF TOWN  MARYLAND  ADDRESS  DOTSET  OF TOWN  MONN  ADDRESS  DOTSET  OF TOWN  MONN  ADDRESS  DOTSET  OF TOWN  MONN  ADDRESS	(Day) (Year)
1. PLACE OF DEATH a. COUNTY St. Iouis  D. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryland Heights  D. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryland Heights  D. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryland Heights  D. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryland Heights  D. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryland Heights  DOTS TOWN Maryland H	(Day) (Year)
1. PLACE OF DEATH a. COUNTY St. Louis  b. CITY (If outside corporate limits, write RURAL and give township) COUNTY TOWN Maryland Heights  d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION  TOWN DOTSett & Mikel Avenues  3. NAME OF a. (First)  DECEASED (Type or Print)  Female  White  White  Widowed  7. MARRIED, NEXT MARRIED, DUSCRED (Specify) Widowed  DUSCRY  HOSPITAL OR (If we kide of work done) diaring most of working life (even if restrict)  B. CALL NAME OF (If not in hospital or institution, give street address or location)  B. (Middle)  C. CITY (If outside corporate limits, write RURAL and give township of NAME (If method of Norwall in the place)  TOWN Maryland Heights  A. STRET (If runs), give location)  TOWN Maryland Heights  A. STRET (If runs), give location)  A. STRET (If runs), give location)  A. DATE (Month)  OF OF OF MARRIED, NEVER MARRIED, DEATH (Month)  DEATH (Month)  DEATH (Month)  OF OF OF MARRIED, DEATH (Month)  DEATH (Month)  OF OF OF MARRIED, NEVER MARRIED, DEATH (Month)  DEATH (Month)  DEATH (Month)  OF OF OF MARRIED, DEATH (Month)  DEATH (Month)  DEATH (Month)  OF OF OF MARRIED, DEATH (Month)  DEATH (Month)  DEATH (Month)  DEATH (Month)  OF OF OF MARRIED, DEATH (Month)  DEATH (Month)  OF OF OF OF MARRIED, DEATH (Month)  DEATH (Month)  DEATH (Month)  DEATH (Month)  DEATH (Month)  OF OF OF OF MARRIED, DEATH (Month)  DEATH (Month)  DEATH (Month)  DEATH (Month)  OF OF OF OF OF MARRIED, DEATH (Month)  DEATH (Month)  OF O	(Day) (Year)
a. COUNTY Stolouis  b. CITY (If outside corporate limits, write RURAL and give township) TOWN Maryland Heights  d. FULL NAME OF (If not in hospital or institution, give street address or location)  A. STREET OR TOWN Maryland Heights  d. FULL NAME OF (If not in hospital or institution, give street address or location)  TOWN Maryland Heights  d. STREET (If rural, give location)  A. STREET ADDRESS  G. CITY (If outside corporate limits, write RURAL and give township OR TOWN Maryland Heights  DOTSOLT & Mikel Avenues  DOTSOLT & Mikel Avenues  3. NAME OF a. (First)  DECEASED (Type or Print)  FOMAL  FOMAL	(Day) (Year)  (Day) (Year)  (Day) Minute Min
TOWN Maryland Heights  d. FULL NAME OF (If not in hospital or institution, give street address or location)  HOSPITAL OR INSTITUTION  DOTSett & Mikel Avenues  3. NAME OF DECEASED (If rural, give location)  (Type or Print)  Bosallie Hedrick Estill  DEATH NOV. 21. 1  5. SEX. 6. COLOR OR RACE NINDOWED, DIVORCED (Specify) Widowed  White Widowed At home  Widowed At home  10a. USUAL OCCUPATION (Cive tind of work done during most of working life, even if retired)  HOUSEWIFE  13b. MOTHER'S MAIDEN NAME  13c. FATHER'S NAME  13c. FATHER'S NAME  13d. FATHER'S NAME  15b. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no., or unknown) (If yes, give war or dates of service)  None  MEDICAL CERTIFICATION  MEDICAL CERTIFICATION  MEDICAL CERTIFICATION  MEDICAL CERTIFICATION  MEDICAL CERTIFICATION	(Day) (Year) 1950 FEAR IF UNDER M HE AYE HOUSE MIS
d. FULL NAME OF (If not in hospital or inatitution, give street address or location) HOSPITAL OR DOTSett & Mikel Avenues  3. NAME OF DECEASED (Type or Print) DECEASED (Month) (OF DECEASED (Month) (DEATH NOV. 21, 1) DEATH NOV. 21, 1 DEATH	(Day) (Year) 1950 TEAR IF UNDER M H AYM HOUSE MI
ADDRESS  INSTITUTION  DOTSett & Mikel Avenues  3. NAME OF DECEASED (A First)  DECEASED	L950 TEAR IF UNDER M H AYM HOUSE MIN COUNTRY?
INSTITUTION Dorsett & Mikel Avenues  3. NAME OF DECEASED (First)  (Type or Print)  5. SEX:  (Female White Wildowed Wildowed Wildowed Wildowed Wildowed Wildowed Wildowed Wildowed At home At home Wildowed At home	L950  FEAR IF UNDER M HE AYE ME HOUSE ME HE COUNTRY?
S. SEX.     6. COLOR OR RACE   7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Speedity)   8. DATE OF BIRTH   9. AGE (In years of working life, even if restred)   10b. KIND OF BUSINESS OR INDUSTRY   11. BIRTHPLACE (State or foreign country)   12.   12.   13a. FATHER'S NAME   13b. MOTHER'S MAIDEN NAME   14. NAME OF HUSBAND OR WIFE   15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY   NO.   None   17. INFORMANT'S SIGNATURE OR NAME   18. CAUSE OF BEATH   MEDICAL CERTIFICATION   MEDICAL CERTIF	L950 TEAR IF UNDER M HE AYM HOUSE MIN
Type or Print   Rosallie   Hedrick   Estill   DEATH   Nov. 21. 1	FEAR IF UNDER M HE HOURS MIN
Female White Widowed 2 Aug. 13.1877 73. 3  10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  HOUSEWIFE at home USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  at home USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  at home USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  at home USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10b. KIND OF BUSINESS OR IN.  11. BIRTHPLACE (State or foreign country)  Wentzville, Mo.  14. NAME OF HUSBAND OR WIFE  15. WAS DECEASED EVER IN U. S. ARMED FORCES?  16. SOCIAL SECURITY  NO.  NO.  NO.  NO.  MEDICAL CERTIFICATION	L CITIZEN OF WH.
Female White  10a. USUAL OCCUPATION (Give kind of work doubled in the control of	CITIZEN OF WHA
10a. USUAL OCCUPATION (Give kind of work doad diring most of working life, even if retired)  10b. KIND OF BUSINESS OR INDUSTRY  11 BIRTHPLACE (State or foreign country).  12 Wentzville, Mo.  13b. MOTHER'S MAIDEN NAME  14 NAME OF HUSBAND OR WIFE  15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. OF UNKNOWN) (If year, give war or dates of service)  17 INFORMANT'S SIGNATURE OR NAME  18 CAUSE OF SEATH  MEDICAL CERTIFICATION	CITIZEN OF WH. COUNTRY? U.S.A.
Housewife at home Wentzville, Mo.  3a. FATHER'S NAME 13b. MOTHER'S MAIDEN NAME 14. NAME OF HUSBAND OR WIFE  John Bonar Delilah Grier Clarence Dcd.  15. WAS DECEASED EVER IN U.S. ARMED FORCES? (You, no., or unknown) (If you, give war or dates of service) NO.  No. None None MEDICAL CERTIFICATION	U.S.A.
3a. FATHER'S NAME  13b. MOTHER'S MAIDEN NAME  14. NAME OF HUSBAND OR WIFE  15. WAS DECEASED EVER IN U. S. ARMED FORCES?  5. WAS DECEASED EVER IN U. S. ARMED FORCES?  16. SOCIAL SECURITY  17. INFORMANT'S SIGNATURE OR NAME  NO.  NO.  NO.  NO.  NO.  MEDICAL CERTIFICATION	
S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. NO. NO. None None None None None None None None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT'S SIGNATURE OR NAME  NO. No. None None Leona Bonar Maryland Heights, Mo.  MEDICAL CERTIFICATION	
No None None Leona Bonar Maryland Heights, Mo-	ADDRESS
R CAUSE OF BEATH MEDICAL CERTIFICATION	
	INTERVAL BETWEE
Enter only one cause per line for (a), (b), and (c) DIRECTLY LEADING TO DEATH*(a) Ohr. Mysearditis	MAL CHAR
ANTECEDENT CAUSES 7 0.0	
" I BU DOES NOT THE ON I TO THE OWNER OF THE OWNER OWNER OF THE OWNER	
is heart fallure, asthenia, rise to the above cause (a) stating	. 45
the Underlying cause tast.  DUE TO (c) Seculety	i.
ion which caused death. II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death well asterioselarose	422
19a. DATE OF OPERA- 19b. MAJOR FINDINGS OF OPERATION 12	20. AUTOPSY?
TION	YES NO
21a. ACCIDENT (Specify)   21b. PLACEOFINJURY (e.g., in or about   21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY)	(STATE)
21a. ACCIDENT (Specify) SUICIDE HOMICIDE  21b. PLACEOF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.)  21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY)	•
21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED 21f. HOW DID INJURY OCCUR?	
OF WHILE AT NOT WHILE INJURY WORK AT WORK	
2. I hereby certify that I attended the deceased from USV-24, 1850, to Nov-24, 1950, that I last so	nin the decens
alive on Nov 24, 1950, and that death occurred at 6:00 P. m., from the causes and on the date stated a	ibove.
	Z3c. DATE SIGNE
	11-27-5
24a. BURIAL, CREMA- TION, REMOVAL (Broadin) 24b. DATE 24c. NAME OF CEMETERY OR CREMATORY 24d. LOCATION (City, town, or county) Burial 21 11-27-1950 Fee Fee Cemetery Pattonville Mo.	,,
DATE REC'D BY LOCAL REGISTRAB'S SIGNATURE / 222 UNERAL DIRECTOR'S SIGNATURE ADDR	PE 33
11/2 7/58EG. Lerbert a Domke Mar 50h-Woodson Rd-Overland-11-Mo.	
(Licensed Employs's Statement on Reverse Side)	

Elever ative arthi

ne is recorded on the reverse side of this certificate was embalmed by me, or by...

working under my personal supervision.

> Note: The above MUST BE-SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with

the above constitutes grounds for revocation of license.) If this body is not embalmed, fact should be so stated above.

Licensed Embalmer No. 345-U